Early implementation of WHO recommendations for the retention of health workers in remote and rural areas

James Buchan,[a] Ian D Couper,[b] Viroj Tangcharoensathien,[c] Khampasong Thepannya,[d] Wanda Jaskiewicz,[e] Galina Perfilieva[f] & Carmen Dolea[g]

Abstract The maldistribution of health workers between urban and rural areas is a policy concern in virtually all countries. It prevents equitable access to health services, can contribute to increased health-care costs and underutilization of health professional skills in urban areas, and is a barrier to universal health coverage. To address this long-standing concern, the World Health Organization (WHO) has issued global recommendations to improve the rural recruitment and retention of the health workforce. This paper presents experiences with local and regional adaptation and adoption of WHO recommendations. It highlights challenges and lessons learnt in implementation in two countries – the Lao People's Democratic Republic and South Africa – and provides a broader perspective in two regions – Asia and Europe. At country level, the use of the recommendations facilitated a more structured and focused policy dialogue, which resulted in the development and adoption of more relevant and evidence-based policies. At regional level, the recommendations sparked a more sustained effort for cross-country policy assessment and joint learning. There is a need for impact assessment and evaluation that focus on the links between the rural availability of health workers and universal health coverage. The effects of any health-financing reforms on incentive structures for health workers will also have to be assessed if the central role of more equitably distributed health workers in achieving universal health coverage is to be supported.

Abstracts in عربي, 中文, Français, Русский and Español at the end of each article.

Introduction

Any shortage of health workers can prevent good access to health services and is a barrier to universal coverage. When such shortages are accompanied by an unequal distribution of the workers, their impact can be even more dramatic.

The maldistribution of health workers between urban and rural or remote areas is a concern in virtually all countries. In Senegal, for example, the Dakar region, which is mostly urban, has more than 60% of the country's physicians but only 23% of the total population.[1] In Canada – where 99.8% of the territory is rural – 24% of the population but only 9.3% of the physicians lived in rural areas in 2006.[2] About one half of the world's population lives in rural and remote areas, but this half is served by only one quarter of the world's doctors and by less than one third of the world's nurses.[3]

Lack of access to health workers in rural and remote areas often leads to relatively high mortality rates in such areas. It also leads to rural residents seeking care at urban health facilities and thus to overcrowding – and increased costs – at urban hospitals. The relatively higher levels of staff in urban areas and facilities may lead to the underutilization of skilled personnel, who may then consider emigration.[4]

In 2010, the World Health Organization (WHO) addressed the long-standing problem of the maldistribution of health workers. First, it facilitated intergovernmental negotiations that led to the adoption – by all of WHO's Member States – of a code of practice for the international recruitment of health personnel.[5] Second, it established a global task force to examine the adverse effects of the intra-country relocation of health workers – mainly from rural to urban areas – which then developed 16 evidence-based recommendations for the improved retention of health workers in remote and rural areas (Table 1).[3] Although no systematic approach to collect in-depth information about the implementation of these recommendations has yet been made, this paper provides broad details of progress across two regions, and more specific details of the lessons learnt in using these recommendations in two countries.

Implementing the recommendations

Adaptation to country context

Lao People's Democratic Republic

Health workers in the Lao People's Democratic Republic are concentrated in cities, although more than 70% of the country's population lives in rural areas.[6] In an attempt to correct this maldistribution, the Laotian health ministry began to develop a strategy for the retention of health workers in those areas. This strategy was built, in part, on the national "2020 Health Personnel Development Strategy" and on a governmental decree that established guidelines for implementing financial incentives for rural civil servants.[7] To assess which of WHO's 16 recommendations would be most effective in the Laotian context, the Ministry of Health – in partnership with Capacity*Plus* and WHO[8] – used a retention survey tool that had been developed from the recommendations[9] to conduct a discrete choice experiment.[10] The results of surveys involving 970 students who were training to become professional health workers and 483 people who were already health workers, indicated that salary levels became less of an issue when a set of other, highly valued incentives, such as promotion and study opportunities, was offered.

[a] Queen Margaret University, Edinburgh, Scotland.
[b] Centre for Rural Health, University of Witwatersrand, Johannesburg, South Africa.
[c] International Health Policy Programme, Ministry of Health, Bangkok, Thailand.
[d] Department of Health Personnel, Ministry of Health, Vientiane, Lao People's Democratic Republic.
[e] IntraHealth International, Chapel Hill, North Carolina, United States of America.
[f] Europe Regional Office, World Health Organization, Copenhagen, Denmark.
[g] Health Systems Policies and Workforce, World Health Organization, 20 avenue Appia, 1211 Geneva, Switzerland.
Correspondence to Carmen Dolea (e-mail: doleac@who.int).
(*Submitted: 10 March 2013 – Revised version received: 31 May 2013 – Accepted: 6 June 2013*)

Table 1. **World Health Organization recommendations to improve the recruitment and retention of health workers in remote and rural areas**

Category of intervention	Examples
Education	Target admission policies to enrol students with a rural background in education programmes for health disciplines
	Locate health professional schools and family medicine residency programmes outside major cities
	During studies, arrange clinical rotations in remote and rural areas
	Revise curricula to reflect the main issues in rural health
	Develop programmes of continuous professional development for rural health workers
Regulation	Introduce enhanced scopes of practice in remote and rural areas
	Introduce different types of health workers in remote and rural areas
	Implement compulsory service in remote and rural areas
	Subsidize education for return of service in remote and rural areas
Financial incentives for health workers in remote and rural areas	Provide appropriate financial incentives
Professional and personal support for health workers in remote and rural areas	Improve living conditions
	Develop a safe and supportive working environment
	Provide outreach support
	Provide career development programmes
	Support the development of professional networks
	Adopt public recognition measures

Source: Adapted from World Health Organization.[3]

Table 2. **Top priorities for rural health care in South Africa, as identified by an expert panel**

Rank	Area of health sector strategy	Priority
1	Human resources for health	There is a need to focus on how to recruit, retain and support senior health-care professionals in rural hospitals for the long term.
2	Governance and leadership	The employment of hospital and medical managers in rural areas should be based on appropriate skills and experience.
3	Human resources for health	There is a need to develop and implement a national "human resource plan" that is relevant in the context of rural health care.
4	Finance	Equitable funding formulae need to be designed for the financing of hospitals, based on the local burden of disease, staffing needs, the costing of services and equity principles.
5	Governance and leadership	The employment of district managers in rural areas should be based on appropriate skills and experience.

Source: Adapted from Versteeg et al.[15]

The Laotian health ministry subsequently used a costing tool[11] to gauge the financial feasibility of implementing the preferred sets of incentives and to assist the relevant policy-makers in their decision-making.

The results of the surveys and costing were used to develop a new, national policy for the recruitment and retention of health workers. This policy – which was announced by the Laotian government in October 2012 – stipulates that all graduates in medicine, nursing, midwifery, pharmacy and dentistry and all postgraduates in family medicine must complete three years of service as a health worker in a rural area before they can receive their licences to practise in their field of study.[12] The policy also stipulates the provision of incentives to encourage new health workers both to provide high-quality services while they work in rural areas and to continue working in a rural area after they have completed their three years of compulsory service. The provided incentives include permanent civil service positions, transportation and eligibility for continued education. The first phase of the implementation of the policy began in early 2013 and focused on 400 newly qualified doctors, pharmacists and dentists who were assigned to health centres and district hospitals serving 142 rural districts.

South Africa

WHO policy guidelines for health worker retention were launched at an event hosted by the University of the Witwatersrand's Centre for Rural Health, in South Africa. At this event, there was a clear call for countries with large rural populations to adapt the global recommendations to their local contexts. The launch event in South Africa, the call for local adaptation and the fact that South Africa faces a severe crisis in its health workforce provided the impetus for a contextualization of WHO guidelines to local – South African – conditions and needs. Thus, in early 2011, a group of national academic and civil society institutions – the University of the Witwatersrand's Centre for Rural Health, the Rural Doctors Association of Southern Africa, the University of KwaZulu-Natal Centre for Rural Health and the University of Cape Town Primary Health Care Directorate – under the leadership of South Africa's Rural Health Advocacy Project developed a document that adapted WHO's recommendations for use in South Africa. The document was distributed for stakeholder review in June 2011 and further inputs were subsequently obtained from Rural Rehabilitation South Africa and the South African Committee of Health Sciences Deans. The "final" contextualization document that was released publicly is a "living document" that is intended to be the basis for continuous discussion and ongoing development.[13] Inputs from all categories of health workers in South Africa and other stakeholders are still being sought.

The contextualization document describes WHO guidelines as long-term strategies, illustrates four categories of interventions with specific examples for South Africa, and makes recommendations for the scaling up of these interventions or for adding to them. The recommendations formulated in this document were submitted to South Africa's national Department of Health, as part of an engagement around the development of a new "human resources for health plan" for South Africa. Many of them were subse-

Table 3. **Policies for improving the recruitment and retention of health workers in five Asian countries**

Type of policy	China	Lao People's Democratic Republic	Sri Lanka	Thailand	Viet Nam
Education					
Students from rural backgrounds	Recruits students from townships for medical education; waives tuition fees and offers subsidies on condition that students serve in rural areas upon graduation	Reserves 10% of places in medical schools for students from the poorest districts	Selects certain categories of health workers on the basis of place of residence	Recruits rural students for medical and nursing education and home-town placement	Recruits medical students from hardship areas for medical education; offers 4 years of "upgrade training" to MD level to medical assistants
Site schools for health professionals outside major cities	–	Three colleges of health sciences and five public health schools located outside major cities	Some training schools for nurses and midwives located outside Colombo	Of 19 medical schools, 12 located outside Bangkok; of 79 nursing schools, 67 located outside Bangkok	Secondary schools and colleges for health professionals run by provincial governments or health departments
Clinical rotations in rural areas during studies	–	–	–	Mandatory clinical rotation to district hospitals for students of all medical and nursing schools	–
Curricula that reflect rural health issues	–	Rural health issues included in curricula for PHC workers and community midwives	Rural health issues included in curricula for all health professionals	Rural health issues included in curricula for all health professionals	–
Continuous professional development	Capacity building for mid-level rural health professionals at county hospitals	–	–	Non-mandatory CPD for doctors and mandatory CPD for nurses, associated with relicensing every 5 years	CPD for all physicians, for a mean of 24 hours per year
Regulatory					
Enhanced scopes of practice	–	Decrees to enhance scopes for nurses and midwives	–	Scopes expanded for nurse practitioners and nurses in fields such as anaesthesiology, dialysis, intensive care and psychiatric services	–
Producing new types of health workers	–	Production of 1500 community midwives in response to MDG commitments	–	–	–
Compulsory service in a rural area	Short-term compulsory rural service for health professionals before they can be promoted	Decrees requiring all new health graduates to serve rural communities for at least 2 years within 5 years of graduation	Compulsory service in a rural area part of national policy but only implemented sporadically	Since 1970s, compulsory service of at least 3 years in rural areas for all health professionals; those failing to comply fined for breach of contract	Compulsory service in a rural area not part of national policy since 1990
Subsidized education for return of service	Medical students recruited from rural townships receive subsidies on condition that they serve in rural areas after they have graduated	–	–	–	–
Financial					
Appropriate financial incentives	–	Decree on the provision of bonuses – of 30%, 40% or 50% of basic salary – to all civil servants, including health workers in "hardship" areas	–	Additional incentives provided, such as hardship allowance, non-private-practice incentive	Decree on the provision of a bonus – of 70% of basic salary – to health workers in most "hardship" areas. Allowance approved for village health workers

(*continues. . .*)

(...*continued*)

Type of policy	China	Lao People's Democratic Republic	Sri Lanka	Thailand	Viet Nam
Professional and personal support					
Outreach support	Technical support and training provided by city hospital counterparts to members of staff in rural county hospitals and township health centres	–	–	–	Health personnel at higher levels required to support clinical services and training at lower levels
Professional networks	–	–	–	Rural Doctor Society established in 1976	–
Public-recognition measures	Annual "village doctor of the year" award	"National health worker" and "community health worker" awards	–	Annual "best rural doctor of the year" and "best rural nurse" awards	–

CPD, continuous professional development; MD, doctor of medicine degree; MDG, Millennium Development Goal; PHC, primary health care.
Source: Adapted from Asia-Pacific Action Alliance on Human Resources for Health.[16]

quently included in the new plan, which was launched in October 2011.[14] As a result of the contextualization document, the plan included a priority area entitled: "Access in rural and remote areas" – as well as seven other priority areas in which issues relating to access to health care in rural areas were also embedded. The partnership being led by the Rural Health Advocacy Project is continuing to engage with the South African Department of Health on the establishment of a taskforce to develop an implementation plan for improving "access in rural and remote areas". A detailed implementation plan has already been drafted by the partnership. More recently, the partnership has been in discussion with the various groups that have been working on the development of human resource norms and indicators for all levels of the health service in South Africa.

The continued importance of WHO's recommendations in the South African context was confirmed by a recent consensus statement made by a panel of rural health experts.[15] This statement listed the top five challenges for health care in rural South Africa (Table 2) and these challenges were mostly workforce issues like those identified in WHO's guidelines.

Policy analysis and mutual learning

Asia perspective

The Asia-Pacific Action Alliance on Human Resources for Health took a joint learning approach to assessing WHO's 16 recommendations. In 2012–2013, the Alliance convened a study to assess policies to improve the retention of health workers in the rural areas of five countries, with reference to WHO recommendations.[16] A policy analysis tool was used to map existing and potential retention strategies – from formulation to implementation – and to assess or predict outcomes. The aims were to scale up the policies that worked well and either scale down the other policies or minimize the barriers to their effective implementation. Initially, only existing policies were investigated (Table 3). Although different sets of relevant interventions were applied in the five study countries, the recruitment of students from rural backgrounds, mandatory rural service by new graduates and the use of financial or non-financial incentives were common. There appears to have been little attempt to evaluate the success of any of these interventions. In a systematic review of retention strategies, the interventions that had been evaluated had multiple effects, at different points on a continuum that ran from the attraction of health workers to their recruitment, retention and impact.[17] For example, the building of schools in rural areas seems to improve the attraction of students at the schools to rural work but appears to have no impact on long-term retention. In contrast, outreach interventions appear to improve the retention and performance of health workers in rural areas but have no significant effect on recruitment.[17] It can be difficult to isolate the impact of any one intervention when several are being implemented at the same time and in the same place. There may be many confounding factors and there may also be a lack of specific "intervention logic" that clarifies the expectations of each intervention's designers.[17,18] Recent theoretical frameworks may help to identify the interplay of the different factors involved by providing a systematic and comprehensive approach for the design, implementation, monitoring, evaluation and review of such interventions.[19,20] Such frameworks make use of a systems approach that differentiates between "impact" – for example, in terms of the attraction and retention of health workers in underserved areas – and "inputs", "outputs" and "outcomes". They provide a set of indicators to measure progress in implementing various strategies and allow their users not only to determine what does or does not work but also to explore the contextual factors that influence success or failure. The frameworks also help to address "heads-on" challenges – such as the absence of baseline indicators – and the need for a multi-stakeholder approach in the design, implementation and impact evaluation of interventions.

The investigations in five Asian countries involved policy-makers from the beginning. It is hoped that the findings will empower policy-makers to take steps to overcome any identified weaknesses and to scale up the workable strategies. The results of the second phase of these investigations – to be published in late 2013 – should help to provide revised, evidence-based, policy options for improving retention strategies in the five study countries.

Europe perspective

In Europe, WHO recommendations have sparked a sustained effort to document existing, related practices in the region, and to facilitate joint learning through

Table 4. **Interventions for improving the recruitment and retention of health workers in five European countries**

Category of intervention	Bulgaria	Republic of Moldova	Tajikistan	The former Yugoslav Republic of Macedonia	Ukraine
Education	Training of mediators to provide ethnic minorities with access to health care	Special admission quotas for students from rural areas	Medical colleges for nurses and midwives in eight rural areas	Special admission quotas for students from minority ethnic groups	A training centre for family physicians in each oblast
Regulation	Introduction of the "health assistant" as a new profession and change in the scope of practice	Bonding contract for 3 years of public health service	3-year bonding contract for scholarship students	Dual practice allowed	Pilot scheme with 3-year bonding contracts after graduation
Financial	Financial compensation through national health insurance, and fund for GPs working in remote areas	Financial incentives for general practitioners, specialists and nurses working in rural areas	Increased salaries for health workers in rural areas	Physicians salaries based on performance, with added compensation for rural work	Salary increase and differential payment based on catchment population
Professional and personal support	Improved access for nurses to medical universities	Housing benefits and electricity for health workers in rural areas, provided by local authorities	Land plots for housing for medical specialists in rural areas	Increased investment of Ministry of Health in public-health facilities and equipment	Transportation, housing support and Internet access for doctors in rural areas

GP, general practitioner.
Source: Adapted from World Health Organization.[21]

a series of subregional workshops organized by WHO and the Royal Tropical Institute in Amsterdam.[21] These workshops have allowed for a detailed mapping of current policies – and an informed exchange on the challenges in implementing them – in 20 countries, notably in the south and east of the region. Initial findings from these countries (Table 4) indicate that the recruitment of health workers to remote and rural areas and their retention in such areas have been promoted by a range of policies covering education, regulation and financial, professional and personal support. However, the success of these systems is often difficult to evaluate. There is a need for situation analysis and impact assessment, which are both identified as important aspects of the successful implementation of WHO guidelines. As the recommended interventions should be "bundled" and can be costly, any mismatch between what is proposed and what may be effective can lead to a substantial waste of resources.

Conclusion

WHO recommendations for the retention of health workers in remote and rural areas have been a useful guide in many countries, particularly for initiating a more structured and focused policy dialogue, strengthening the collection of evidence and supporting policy development. However, more effective mechanisms to share the lessons learnt, to assess impact and to explore the links between the rural availability of health workers and universal health coverage are needed. Such mechanisms should help answer several critical policy questions, including: "How do different types of retention interventions really work?" and "What are the contextual factors that most influence intervention success?" We also need to know how comprehensive situation analysis can be conducted so that policy responses can be aligned with the expectations and needs of health workers, and so that the most effective mix or "bundle"[19] of interventions in any given context can be identified.

At a ministerial level meeting held in February 2013, effective distribution of health workers was identified as a key component in achieving universal health coverage.[22] Such coverage is also predicated on reforms in health financing. If the central role to be played by equitably distributed health workers in achieving universal health coverage is to be supported, the effects of these finance-related reforms on incentive systems for health workers will also have to be assessed.[23,24] ■

Competing interests: None declared.

ملخص

التنفيذ المبكر لتوصيات منظمة الصحة العالمية للاحتفاظ بالعاملين الصحيين في المناطق النائية والريفية

يعتبر سوء توزيع العاملين الصحيين بين المناطق الحضرية والريفية أحد شواغل السياسة في كل البلدان تقريباً. وهو يحول دون الوصول العادل إلى الخدمات الصحية، ويمكن أن يسهم في زيادة تكاليف الرعاية الصحية وقصور استغلال المهارات المهنية الصحية في المناطق الحضرية، كما يمثل عائقاً أمام التغطية الصحية الشاملة. ولمعالجة هذا الشاغل طويل الأمد، أصدرت منظمة الصحة العالمية (WHO) توصيات عالمية لتحسين التوظيف في المناطق الريفية والاحتفاظ بقوة العمل الصحية. ويعرض هذا البحث الخبرات الخاصة بالتكييف المحلي والإقليمي وتبني توصيات منظمة الصحة العالمية. وهو يسلط الضوء على التحديات والدروس المستفادة من التنفيذ في بلدين – جمهورية لاوس الديمقراطية الشعبية وجنوب أفريقيا – ويقدم منظوراً أوسع في إقليمين – آسيا وأوروبا. وقد ساعد استخدام التوصيات، على مستوى البلدان، على الوصول إلى حوار سياسي أكثر تنظيماً وتركيزاً، وهو ما نتج عنه وضع وتبني

سياسات أكثر صلة وتستند إلى الأدلة. أما على المستوى الإقليمي، فقد أسهمت التوصيات في بدء جهود أكثر استدامة لتقييم السياسة عبر البلدان والتعلم المشترك. وهناك حاجة لتقييم وتقدير التأثير الذي يركز على الروابط بين التوفر الريفي للعاملين الصحيين والتغطية الصحية الشاملة. وسينبغي أيضاً تقييم تأثيرات أية إصلاحات للتمويل الصحي على هياكل الحوافز للعاملين الصحيين، إذا كانت هناك حاجة لدعم الدور المركزي الذي يؤديه التوزيع الأكثر عدلاً للعاملين الصحيين في تحقيق التغطية الصحية الشاملة.

摘要

世卫组织留住偏远和农村地区卫生工作者建议的早期实施

城市和农村地区卫生工作者配置不合理的问题在几乎所有国家都是一个政策考虑。这种不均衡妨碍了人们公平获取卫生服务，可能增加造成更高卫生保健成本，使城市地区卫生专业人员的技能得不到充分利用，成为实现全民医疗保障制度的拦路虎。为解决这一长期存在的问题，世界卫生组织（WHO）发出了聘用和留住更多农村卫生工作者的全球建议。本文介绍了因地制宜采纳 WHO 建议的经验。文中重点介绍两个国家（老挝和南非）在实施中的挑战和经验教训，并展望了亚洲和欧洲这两个区域的大形势。在国家层次上，这些建议的采纳促进了更结构化、更有针对性的政策对话，从而促成更加中肯并以证据为基础的政策的制定和实施。在区域层次上，这些建议激发了人们投入更加持久的努力进行各国间政策的评估和共同学习。文中指出针对农村卫生工作者可及性和全民医保制度之间的关系，需要进行效果的评估和评价。在实现全民医保的过程中，如果能够发挥卫生工作者更合理配置的核心作用，则还必须对卫生工作者激励结构的所有卫生筹资改革效果进行评估。

Résumé

Mise en œuvre anticipée des recommandations de l'OMS pour la rétention des travailleurs de la santé dans les régions rurales et excentrées

La mauvaise répartition des travailleurs de la santé entre les zones urbaines et rurales demeure une préoccupation politique dans pratiquement tous les pays. Elle empêche l'accès équitable aux services de santé, elle peut contribuer à une augmentation du coût des soins de santé et de sous-utilisation des compétences des professionnels de la santé dans les zones urbaines, et elle représente un obstacle à la mise en place d'une couverture maladie universelle. Pour répondre à cette préoccupation qui existe depuis longtemps, l'Organisation mondiale de la Santé (OMS) a émis des recommandations visant à améliorer le recrutement et la rétention des travailleurs du secteur de la santé en milieu rural. Ce document présente différentes expériences locales et régionales concernant l'adaptation et l'adoption des recommandations de l'OMS. Il souligne les défis et les leçons tirées de mises en œuvre dans deux pays - en République démocratique populaire lao et en Afrique du Sud - et il offre une perspective plus vaste dans deux régions - en Asie et en Europe. Au niveau des pays, l'application des recommandations a permis un dialogue plus structuré et plus ciblé sur les règlementations, qui a abouti à l'élaboration et à l'adoption de politiques plus pertinentes basées sur les faits. Au niveau régional, les recommandations ont suscité un effort plus soutenu en ce qui concerne l'évaluation des politiques entre les pays et leur apprentissage commun. Il faut évaluer l'impact des liens qui existent entre la disponibilité des travailleurs de la santé dans les zones rurales et la couverture maladie universelle. Les effets de toutes les réformes financières sur les structures d'incitation des travailleurs de la santé devront également être évalués si le but principal est de répartir plus équitablement les travailleurs de la santé et d'atteindre une couverture maladie universelle.

Резюме

Первые итоги реализации рекомендаций ВОЗ по удержанию работников здравоохранения на рабочих местах в отдаленных и сельских районах

Неравномерное распределение работников здравоохранения между городскими и сельскими районами представляет собой проблему для политики здравоохранения практически во всех странах. Данная проблема не позволяет обеспечить равный доступ к медицинским услугам, может способствовать увеличению расходов на здравоохранение и недостаточно эффективному использованию профессиональных навыков работников здравоохранения в городских районах, а также является препятствием для всеобщего охвата населения медико-санитарными услугами. Для решения этой давней проблемы Всемирная организация здравоохранения (ВОЗ) опубликовала глобальные рекомендации по совершенствованию найма и удержания трудовых ресурсов здравоохранения в сельских районах. В этой статье описывается опыт адаптации и внедрения рекомендаций ВОЗ на местном и региональном уровнях. В ней освещаются проблемы и извлеченные уроки при применении рекомендаций в двух странах — в Лаосской Народно-Демократической Республике и Южной Африке, а также дается более широкий обзор для двух регионов — Азии и Европы. На уровне стран использование рекомендаций способствовало более структурированному и целенаправленному диалогу по вопросам выработки политики, что привело к разработке и принятию более обоснованной политики, основанной на фактах. На региональном уровне рекомендации стимулировали более последовательные усилия по сравнительным оценкам политик в различных странах региона и их совместному осмыслению. Существует необходимость проведения оценки последствий политик и анализа, в ходе которого основное внимание должно уделяться связям между наличием работников здравоохранения в сельских районах и всеобщим охватом населения медико-

санитарными услугами. Кроме того, необходимо также оценить влияние всех реформ финансирования здравоохранения на структуры стимулирования работников здравоохранения, если придерживаться точки зрения, что более справедливое распределение работников здравоохранения является ключевым фактором для обеспечения всеобщего охвата населения медико-санитарными услугами.

Resumen

La aplicación temprana de las recomendaciones de la OMS para la conservación del personal sanitario en zonas rurales y remotas

La distribución ineficaz del personal sanitario entre las zonas urbanas y rurales constituye una preocupación política en casi todos los países, pues impide el acceso equitativo a los servicios sanitarios, puede contribuir al aumento de los costes de atención sanitaria y la infrautilización de las capacidades profesionales sanitarias en las zonas urbanas, y obstaculiza la cobertura sanitaria universal. Para solucionar este problema de larga data, la Organización Mundial de la Salud (OMS) ha publicado una serie de recomendaciones generales para mejorar la contratación a nivel rural y la conservación del personal sanitario. Este informe presenta las experiencias en relación con la adaptación local y regional, y la adopción de las recomendaciones de la OMS. Además, subraya los desafíos y las lecciones aprendidas de la aplicación en dos países, la República Democrática Popular Lao y Sudáfrica, y proporciona una perspectiva más amplia en dos regiones, en concreto, Asia y Europa. A nivel nacional, el uso de las recomendaciones facilitó un diálogo político más organizado y específico, lo que permitió el desarrollo y la adopción de políticas más relevantes con base empírica. A nivel regional, las recomendaciones motivaron un esfuerzo más firme para evaluar las políticas entre los países y el aprendizaje conjunto. Es necesario realizar una evaluación y una valoración del impacto que se centren en la relación entre la disponibilidad de personal sanitario en zonas rurales y la cobertura sanitaria universal. Asimismo, deben evaluarse los efectos de las reformas financieras en asistencia sanitaria sobre las estructuras de incentivos para el personal sanitario con miras a promover el papel central del mismo, distribuido de forma más equitativa, en la consecución de la cobertura sanitaria universal.

References

1. Zurn P, Codjia L, Sall FL, Braichet JM. How to recruit and retain health workers in underserved areas: the Senegalese experience. *Bull World Health Organ* 2010;88:386–9. doi: http://dx.doi.org/10.2471/BLT.09.070730 PMID:20461134
2. Dumont J-C, Zurn P, Church J, Le Thi C. *International mobility of health professionals and health workforce management in Canada: myths and realities*. Paris: Organization for Economic Co-operation and Development; 2008. Available from: http://www.oecd.org/canada/41590427.pdf [accessed 25 July 2013].
3. *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations*. Geneva: World Health Organization; 2010. Available from: http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf [accessed 25 July 2013].
4. Dussault G, Franceschini MC. Not enough there, too many here: understanding geographical imbalances in the distribution of the health workforce. *Hum Resour Health* 2006;4:1–12. doi: http://dx.doi.org/10.1186/1478-4491-4-12 PMID:16438710
5. *The WHO global code of practice on the international recruitment of health personnel*. Geneva: World Health Organization; 2010. Available from: http://www.who.int/hrh/migration/code/code_en.pdf [accessed 25 July 2013].
6. *Annual report of the Department of Organization and Personnel*. Vientiane: Ministry of Health; 2011.
7. Buchan J, Weller B. *Health worker incentives, Lao People's Democratic Republic; final report*. Manila: World Health Organization; 2013. Forthcoming.
8. Jaskiewicz W, Phathammavong O, Vangkonevilay P, Paphassarang C, Phachanh IT, Wurts L. *Toward development of a rural retention strategy in Lao People's Democratic Republic: understanding health worker preferences*. Washington: Capacity*Plus*; 2012. Available from: http://www.capacityplus.org/files/resources/Toward-Development-of-a-Rural-Retention-Strategy-in-Lao-PDR.pdf [accessed 8 June 2013].
9. Jaskiewicz W, Deussom R, Wurts L, Mgomella G. *Rapid retention survey toolkit: designing evidence-based incentives for health workers*. Washington: Capacity*Plus;* 2012. Available from: http://www.capacityplus.org/files/resources/Rapid_Retention_Survey_Toolkit.pdf [accessed 8 June 2013].
10. Lagarde M, Blaauw D. A review of the application and contribution of discrete choice experiments to inform human resources policy interventions. *Hum Resour Health* 2009;7:62. doi: http://dx.doi.org/10.1186/1478-4491-7-62 PMID:19630965
11. *iHRIS retain. Cost health worker retention interventions.* Washington: Capacity*Plus;* 2013. Available from: http://retain.ihris.org/retain/ [accessed 8 June 2013].
12. Capacity*Plus* [Internet]. Laotian health workforce recruitment and retention policy informed by use of Capacity*Plus* tools. Washington: Capacity*Plus*; 2012. Available from: http://www.capacityplus.org/laotian-health-workforce-recruitment-retention-policy [accessed 25 July 2013].
13. *The WHO global policy recommendations on increasing access to health care workers in remote and rural areasthrough improved recruitment and retention: the South African context*. Braamfontein: Rural Health Advocacy Project; 2011.
14. *Human resources for health South Africa 2030*. Pretoria: National Department of Health; 2011.
15. Versteeg M, du Toit L, Couper I. Building consensus on key priorities for rural health care in South Africa using the Delphi technique. *Glob Health Action* 2013;6:1–8. doi: http://dx.doi.org/10.1186/1478-4491-4-12 PMID:16438710
16. Asia-Pacific Action Alliance on Human Resources for Health Newsletter [Internet]. AAAH Research Workshop, 18-19th April 2012 at Siam City Hotel, Bangkok. Mueang Nonthaburi: AAAH; 2012. Available from: http://www.aaahrh.org/pdf/Newsletter_Year_6_Issue2_Mar_Apr_2012%20(1).pdf [accessed 25 July 2013].
17. Huicho L, Dieleman M, Campbell J, Codjia L, Balabanova D, Dussault G et al. Increasing access to health workers in underserved areas: a conceptual framework for measuring results. *Bull World Health Organ* 2010;88:357–63. doi: http://dx.doi.org/10.2471/BLT.09.070920 PMID:20461135
18. Dieleman M, Kane S, Zwanikken P, Gerretsen B. *Realist review and synthesis of retention studies for health workers in rural and remote areas*. Geneva: World Health Organization; 2011. Available from: http://whqlibdoc.who.int/publications/2011/9789241501262_eng.pdf [accessed 25 July 2013].
19. Dolea C, Stormont L, Braichet JM. Evaluated strategies to increase attraction and retention of health workers in remote and rural areas. *Bull World Health Organ* 2010;88:379–85. doi: http://dx.doi.org/10.2471/BLT.09.070607 PMID:20461133
20. *Monitoring, evaluation and review of national health strategies: a country-led platform for information and accountability*. Geneva: World Health Organization; 2011. Available from: http://www.internationalhealthpartnership.net/en/tools/monitoring-evaluation-platform/ [accessed 25 July 2013].
21. *Attracting and retaining health workers in the Member States of the South-eastern Europe Health Network: a policy brief*. Copenhagen: World Health Organization; 2012. Available from: http://www.euro.who.int/__data/assets/pdf_file/0013/152203/e95774.pdf [accessed 8 June 2013].
22. *WHO/World Bank Ministerial-level Meeting on Universal Health Coverage 18–19 February 2013, WHO headquarters, Geneva, Switzerland*. Geneva: World Health Organization; 2013. Available from: http://www.who.int/health_financing/ministerial_meeting_report20130328.pdf [accessed 25 July 2013].
23. Buchan J. What difference does ("good") HRM make? *Hum Resour Health* 2004;2:6. doi: http://dx.doi.org/10.1186/1478-4491-2-6 PMID:15182378
24. Hoffman L. *Right time, right place*. London: BioMed Central; 2013. Available from: http://blogs.biomedcentral.com/bmcblog/2013/03/21/right-time-right-place/ [accessed 25 July 2013].